

Division of Workers' Compensation

PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT (PR-2)

Check the box(es) which indicate why you are submitting a report at this time. If the patient is "Permanent and Stationary" (i.e., has reached maximum medical improvement), do not use this form. You may use DWC Form PR-3 or IMC Form 81556.

<input type="checkbox"/> Periodic Report (required 45 days after last report)	<input type="checkbox"/> Change in treatment plan	<input type="checkbox"/> Released from care Discharged
<input type="checkbox"/> Change in work status	<input type="checkbox"/> Need for referral or consultation	<input type="checkbox"/> Response to request for information
	<input type="checkbox"/> Info. requested by _____	
<input type="checkbox"/> Change in patient's condition	<input type="checkbox"/> Need for surgery or hospitalization	<input type="checkbox"/> Other: _____

Patient:

Last _____ First _____ M.I. _____ Sex _____
 Address _____ City _____ State _____ Zip _____
 Date of Injury _____ Date of Birth _____
 Occupation _____ SS # _____ - _____ - _____ Phone (____) _____

Claims Administrator:

Name _____ Claim Number _____
 Address _____ City _____ State _____ Zip _____
 Phone (____) _____ FAX (____) _____

Employer name:

Employer Phone (____) _____

The information below must be provided. You may use this form or you may substitute or append a narrative report.

Subjective complaints:

Objective findings: (Include significant physical examination, laboratory, imaging, or other diagnostic findings.)

Diagnoses:

1. _____ ICD-9 _____
2. _____ ICD-9 _____
3. _____ ICD-9 _____

Treatment Plan: (Include treatment rendered to date. List methods, frequency and duration of planned treatment(s). Specify consultation/referral, surgery, and hospitalization. **Identify each physician and non-physician provider.** Specify type, frequency and duration of physical medicine services (e.g., physical therapy, manipulation, acupuncture). Use of CPT codes is encouraged. Have there been any **changes** in treatment plan? If so, why?

Work Status: This patient has been instructed to:

- ☐ Remain off-work until _____.
- ☐ Return to *modified* work on _____ with the following limitations or restrictions
 (List all specific restrictions re: standing, sitting, bending, use of hands, etc.): _____
- ☐ Return to full duty on _____ with no limitations or restrictions.

Primary Treating Physician: (original signature, do not stamp)

Date of exam: _____

I declare under penalty of perjury that this report is true and correct to the best of my knowledge and that I have not violated Labor Code § 139.3.

Signature: _____ Cal. Lic. # _____

Executed at: _____ Date: _____

Name: _____ Specialty: _____

Address: _____ Phone: _____

Next report due no later than _____